

not. 3. A cure of the laryngeal tuberculosis will most probably never be obtained. With regard to No. 2, he says, however, that (a) the situation of the ulcers on the epiglottis, ventricular bands, in the ventricles, etc., (b) the simultaneous existence of ulcers on several of these places, (c) the intensity, depth, and extension of the ulceration, (d) its duration and incurability, will often permit us to diagnose with a great deal of probability, the tubercular nature of the process, without having recourse to examination of the lungs, etc.—*London Med. Record*, Jan. 15, 1879.

Syphilitic Affections of the Larynx.

In the first part of a contribution to the study of respiratory troubles in syphilitic disease of the larynx (*Annales des Maladies de l'Oreille, du Larynx, et des Organes connexes*, September, 1878), M. KRISHABER begins by alluding to the period of the disease at which laryngeal affections appear, and is of opinion that it is impossible to assign a limit to the time at which they may develop. According to an analysis of cases made by himself and Mauriac at the Hôpital Midi, the earlier syphilitic eruptions of the larynx appeared from two to six months after the primary sore; only once was the interval so great as ten months. The later affections are frequently met with after an interval of perfect health, long after infection, generally about four or five years, but also ten or fifteen, and even much later than this. Sometimes, many years after infection a simple erythema occurs, whose specific character is only revealed by the subsequent appearance of grave symptoms. What seems to be a simple laryngeal catarrh, some time after contamination, may give rise to œdema endangering life; and it is most important to remember that œdema may complicate all forms of syphilitic laryngeal disease, whether recent or of older date. Any laryngeal trouble in a syphilitic subject, though only seeming due to a cold, should be treated as of grave import.

Syphilitic vegetations form most frequently without œdema. They grow very slowly, and attack, in order of frequency, the true vocal cords, the false vocal cords, the subglottic mucous membrane, and lastly, any other part of the laryngo-tracheal cavity. The lesions consist of a kind of membranous prolapse at the level of the vocal cords, arising sometimes from one or other surface, and forming a sort of diaphragm which tends finally to bring about complete obstruction. Sometimes true polypoid vegetations occur. It is easy to distinguish syphilitic from simple polypi, as the latter form in a healthy organ, whereas the former are only consecutive to previous lesions, generally ulcerative. There is no clear local sign of distinction between syphilitic and cancerous or tuberculous growths; the diagnosis must be made from other facts connected with the case.

Another form of syphilitic narrowing is caused by the cicatricial contraction of the tissues after loss of substance from deep and extensive ulceration; but when the mucous membrane only is affected, it recovers wonderfully under specific treatment, and it is sometimes scarcely possible to find any trace of the lesion afterwards. Although the acute stenoses are promptly influenced by treatment, the author has never seen the chronic form regress under any kind of medication.

The chronic stenoses are divided into three classes, as follows:—

1. Where the glottis is obliterated, and respiration is carried on through the tracheal canula; voice abolished.

2. *Inspiratory stenosis*.—Patients are unable to inspire sufficient air, but can expire enough to cause sonorous vibrations of the vocal cords, if these be not too much implicated; hence there is some degree of voice. Such patients also require tracheotomy.

3. *Incomplete laryngo-stenosis*.—Tracheotomy has been avoided. The lesion is arrested, but no improvement occurs. The patients breathe sufficiently to live,

if kept quiet, and no complication arise. They may enjoy fair health. The voice is more or less normal.

In these cases wheezing or whistling breathing (*bruit de cornage*) is not in direct relation to the intensity of the lesion.

The *prognosis* of syphilitic laryngo-stenoses is arrived at especially by noticing the evolution of respiratory symptoms. If these come on slowly, they constantly indicate insidious organic disease leading to a serious result. If, on the contrary, disorders of respiration occur rapidly, they indicate a state of imminent danger; but one capable of being promptly relieved by energetic treatment. Syphilitic lesions are generally more grave in the trachea than in the larynx, and laryngeal lesions are of more serious import in the subglottic portion than when situated above the vocal cords. Œdema appears to happen most frequently after a chill. Krishaber thinks it well to consider most cases of œdema in non-tuberculous persons as being syphilitic, whether cold be or be not assigned as the cause; and calls attention to the fact that œdema of the larynx is rare apart from any diathesis, while in diathetic affections it is the reverse. Therefore, bearing in mind the possibility of relieving syphilitic œdema by general treatment, and without any operation, it is rational to admit the presumption of syphilis, and to act accordingly, although the diagnosis be uncertain.

The *treatment* recommended to prevent relapse, which is always so likely to occur, is as follows: Once the cure obtained, the patient is to be left without treatment for an entire month. Afterwards, during the first eight days of each month, a teaspoonful of Van Swieten's solution (solution of perchloride of mercury), and during the last eight days of each month a gramme (15 grains) of iodide of potassium. This treatment is to be continued for about a year, for it has been abundantly proved that a patient who has had laryngeal symptoms, however slight, is liable to relapse under the most severe form, after premature cessation of treatment. The author concludes this part of his paper by giving reports of five cases, showing how tracheotomy may be avoided in some of the most urgent cases of laryngeal syphilis, provided the affection be recognized, and active general treatment promptly carried out.

CASE I. was one of acute laryngo-stenosis, without œdema (which is rare), due to a syphilitic tumour of the thyroid cartilage causing displacement of the whole larynx. The tumour disappeared under active treatment, and without tracheotomy, although the patient was almost asphyxiated when first seen.

CASE II. was that of a patient, aged 45, with multiple erosions and œdema of the larynx. The patient, though improving under treatment, neglected to attend. When next seen, the difficulty of breathing was so great that tracheotomy was proposed. The patient, however, refused to submit to the operation, and quite recovered under the active administration of mercury and iodide of potassium.

CASES III. and IV. also illustrate the good effects of active treatment; both were extremely severe, one having been sent for immediate tracheotomy.

CASE V. was that of a patient aged 42, sent to M. Krishaber for tracheotomy on account of extreme difficulty of breathing. The laryngoscope showed inflammatory œdematous swelling of the epiglottis, and false vocal cords, and œdema below the glottis. Under active mixed treatment, respiration became normal in fourteen days. Nitrate of silver was also applied locally, but did not seem to have any good effect.—*London Med. Record*, Dec. 15, 1878.

The Treatment of Diphtheria.

Professor KLEBS, of Prague, describes in the *Med.-Chir. Centralblatt*, No. 22, a series of experiments performed on himself and other persons to test the efficacy of benzoate of soda in destroying the formation of microscopic fungi in